	PEBB Statewide		Providence Choice		Moda Synergy	
Regional Service Area	Statewide and Nationwide		Benton, Clackamas, Clatsop, Hood River, Lane, Lincoln, Linn, Marion, Multnomah, Polk, Wasco, Washington, Yamhill in Oregon; Clark, Walla Walla in Washington		Benton, Clackamas, Clatsop, Lane, Linn, Marion, Multnomah, Polk, Tillamook, Wasco, Washington, Yamhill in Oregon; Clark in Washington	
Services	In-Network	Out-of-Network	In-Medical Home	Out-of-Medical Home	In-Network	Out-of-Network
Standard Plan Deductible	$250/Individual $750/Family Waived on first four primary care visits	$500/Individual $1,500/Family	$250/Individual $750/Family Waived on first four primary care visits	$500/Individual $1,500/Family	$250/Individual $750/Family Waived on first four primary care visits	$500/Individual $1,500/Family
HEM Non-Participation	Additional deductible: $100/person, $300/family (Applies to ail services unless otherwise noted)					
Out-of-Pocket Maximum (some deductibles co-pays and services do not apply)	$1,900/Individual $5,700/Family	$4,800/Individual $14,400/Family	$1,500/Individual $4,500/Family	$4,000/Individual $12,000/Family	$1,500/Individual $4,500/Family	$4,000/Individual $12,000/Family
Primary Care	15%	30%	$10	30%	$10	30%
Chronic Care Visits	0%, no deductible	30%	0%. No deductible	30%	0%, no deductible	30%
Specialty Visits	15%	30%	$10 w/referral	30%	$10 w/referral	30%
Mental Health Care	Cost same as medical services					
Maternity & Childbirth	0%, no deductible	30%	0%, no deductible	30%	0%, no deductible	30%
Delivery	Inpatient delivery subject to inpatient hospital charges					
Preventative Care	0%, no deductible	30%	0%, no deductible	30%	0%, no deductible	30%
Lab & X-Ray	15%	30%	0%, no deductible	30%	0%, no deductible	30%
Inpatient hospital per admission	15%	$500 + 40%	$50/day $250 maximum	$500 +40%	$50/day $250 maximum	$500 +40%
Emergency Room	$150 +15%	$100+15%	$150	$150	$150	$150
Urgent Care	15%	15%	$25	$25	$25	$25
Insulin & Diabetic Supplies	$0 or 0%, no deductible					
Alternative Care Office Visits	15%	30%	$10	30%	$10	30%
Spinal Manipulation Acupuncture & Massage Therapy	15%, up to 60 services per year*	30%, up to 60 services per year	$10, $1000 maximum benefit per year	30%, $1000 maximum benefit per year	$10, $1000 maximum benefit per year	30%, $1000 maximum benefit per year

Deductibles and Out-of-pocket maximums accumulate separately and are not combined

***Massage therapy not available on the PEBB Statewide plan**

	Kaiser Traditional	KaiserDeductible
Regional Service Area	Zip codes in Benton, Clackamas, Columbia, Hood River, Lane, Linn, Marion, Multnomah, Polk, Washington and Yamhill in Oregon; Clark, Cowlitz, Lewis, Skamania 8: Wahkiakum in Washington	
Services	Kaiser Network	
Standard Plan Deductible	$0	$250/Individual $750/Family Office visits and some services notsubject
HEM Non-Participation	Additional deductible: $100/individual, $300/family	
Out-of-PocketMaximum (some deductibles co-pays and services do not apply)	$600/Individual $1200/Family	$1500/Individual $4500/Family
PrimaryCare	$5	$5, deductible waived
Chronic CareVisits	$5	$5, deductible waived
Specialty Visits	$5w/Referral	$5 w/referral, deductible waived
Mental Health Care	Cost same as medicalservices	
Maternity & Childbirth Services	$0	$0, deductible waived
Delivery	Inpatient delivery subject to inpatient hospital charges	
Preventative Care	$0	$0, deductible waived
Lab &X-Ray	$0	$15, deductible waived
Inpatient hospital per admission	$50/day up to $250maximum	$50/day up to $250maximum
EmergencyRoom	$75	$75
Durable Medical Equipment	$0	15%, deductible waived
Insulin & Diabetic Supplies	$0, deductible waived	
Alternative Care Office Visits	$10	$10, deductible waived
Spinal Manipulation/Acupuncture & Massage Therapy	$10, massage therapy not covered	$10 spinal manipulation/acupuncture; $25 massage therapy deductible waived

Vision Service Plan - VSP

Select one of the plans below to enroll in vision coverage		
	Basic Plan	**Plus Plan**
Exam	$10 copay	$10 copay
Frames	$25 copay, $150 allowance	$25 copay, $225 allowance
Lenses	Single, lined bifocal and trifocal covered in full Discounts available on progressives	$20 copay Anti-reflective coatings $20 copay Progressive Lenses
Contact Lens - Instead of glasses	$200	$200
SunCare	Free eye exam and non-prescription sunglasses from VSP provider in place of prescription glasses or contacts	

- Benefits provided every calendar year
- VSP preferred providers bill VSP directly.
- Non-VSP provider: Coverage is at a reduced rate. You pay out-of-pocket for the services and submit receipts to VSP for reimbursement.
- VSP does not apply to Kaiser medical plan. Vision benefits are provided by Kaiser facilities.
- Access benefits using your PEBB IDnumber.

For a listing of VSP providers : https://vsp.com/

Vision Plan Monthly Premiums								
Plan Name	Employee		Employee & Spouse/Partner		Employee & Children		Employee & Family	
	100%	5%	100%	5%	100%	5%	100%	5%
VSP Basic Plan	$8.54	$.43	$17.08	$.85	$14.52	$.73	$23.06	$1.15
VSP Plus Plan	$6.41+ .43 = **$6.84**		$12.81 + .85 = **$13.66**		$10.89 + .73 = **$11.62**		$17.29 + 1.15 = **$18.44**	

Dental Plans Comparison					
Plans	**Kaiser**	**Willamette**	**Delta Dental**		
			Premier	**PPO**	
Providers	**Kaiser**	**Willamette**	**Any**	**Preferred**	**Non-preferred***
Annual/person maximum	$1750	None	$1,750	$1,750	$1,750
Type of Service and Amount You Pay					
Annual deductible (individual; family)	None	None	$50; $150	$50; $150	$50; $150
Diagnostic & Preventative (cleanings, x-rays)[1]	0%	$10	0%	0%	10%
Fillings	20%	$20	20%	20%/10%/0%[2]	30%
Root Canals	$5 + 20%	$150	20%	20%	50%
Oral Surgery	$5 + 20%	$40	20%	20%	50%
Crowns & Bridges	$5 + 25%	$250[3]	50%	50%	50%
Implants	$5 + 50%	varies	50%	50%	50%
Dentures	$5 + 50%	$290	50%	50%	50%
Orthodontia	$5 + 50%[4]	$2,500[5]	50%[4]	50%[4]	50%[4]

[1] Routine cleaning covered twice per year for patients with no risks; up to four cleanings per year covered based on dentist's assessment of patient's risks and health indicators. X-rays covered on age-based schedule. Does not accrue towards annual maximum.
[2] Decreases by 10% per calendar year if you visit preferred dentist at least once per year
[3] Co-payment per tooth for crowns and bridges
[4] Limited to lifetime maximum of $1,500 per person
[5] Total out-of-pocket maximum
* May be balanced billed for services received out-of-network